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Recovery research: the empirical evidence from England

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Bellack and Drapalski provide an expert overview of the implications of the "consumer recovery model", giving a primarily USA-based perspective on challenges of definition, assessment and treatment outcomes. These important topics have also been addressed in England, and in this commentary some recent findings are outlined.

In relation to definition, scientific enquiry has moved beyond consensus statements. A systematic review identified all published English-language descriptions and models of recovery (1). Narrative synthesis was then used to develop a conceptual framework consisting of: a) thirteen common characteristics of the recovery journey; b) five recovery processes, comprising connectedness, hope and optimism about the future, identity, meaning in life, and empowerment (giving the acronym CHIME); and c) recovery stage descriptions.

The CHIME framework is applicable internationally (2), and an evidence base for supporting recovery requires interventions whose primary outcomes are the identified CHIME recovery processes. The existing evidence base has a different focus, reflecting traditional clinical priorities of symptomatology and functioning, so for example well-evaluated interventions targeting connectedness ("community integration" in the USA, "social inclusion" in the UK and Australia) are largely absent from the research base and hence from clinical guidelines.

Bellack and Drapalski note the problematic inclusion in the consensus statement of items at different levels: individual, environment, treatment, etc. Two systematic reviews of recovery measures have been published (3, 4), which also identify the twin problems of inconsistent definitions of recovery and assessment spanning different levels. Therefore the CHIME framework has been used as a foundation for a new measure of recovery support from services. The measure – called INSPIRE (described at researchintorecovery.com/inspire) – addresses the challenge that service users vary in the importance they attach to different types of support, and so is a utility measure intended for use both in routine clinical settings and as a clinical end-point in trials.

Turning to services, a review of international standards and guidelines has been undertaken to develop recovery-oriented practice guidance (5). Qualitative analysis of thirty best practice documents using inductive, semantic-level thematic analysis identified sixteen dominant themes, which were grouped using interpretive analysis. Four practice domains were identified: supporting personally defined recovery, working relationships, organizational commitment, and promoting citizenship. Supporting personally defined recovery involves *offering* evidence-based interventions as a resource for the service users to use in their recovery journey, rather than imposing treatments in their best interests. The second domain of working relationships is central because synthesized evidence from qualitative research and recovery narratives shows that turning points in the lives of people using services are often linked to authentic encounters with clinicians. Put colloquially, for clinicians it's not just what you do (i.e., what treatments you offer) but how you do it.

The third domain of organizational commitment highlights the impact of beliefs about core business ("what we're really here to do"), which shape expectations, discourse and behaviour. For example, if the core business of the mental health

system is public protection, then the positive risk-taking which is needed to grow as a human will be discouraged. The final domain of promoting citizenship underlines that service users are more than their illness. A recovery orientation involves changing the centre of gravity from treating illness (so the person can subsequently get on with his/her life) to supporting personhood and citizenship (to which end treatments may contribute, for some people at some points in their life). One litmus test for this shift may be the extent to which it is perceived to be as much part of the job for a clinician to work with a local employer, training him/her to make the work-place adjustments needed for people with mental health problems to work, as it is to provide treatment for individuals. Indeed, it has been argued that clinicians of the future will need to become social activists (6).

Two initiatives in England can be positioned within these four practice domains. At the level of organizational commitment, 30 of 55 mental health trusts (service provider groups) are involved in the ImROC project (7). This is founded on a framework of ten key “organizational challenges”, developed through co-production in workshops involving over 300 mental health staff, service users and family members (8). The challenges include workforce transformation (e.g., towards a workforce in which 50% of care delivery is by peer professionals who have personal experience of mental illness), a transition from risk-oriented to safety-oriented services, and establishment of recovery education centres in which staff and service users can learn from the expertise of each other.

A team-level intervention has also been developed for adult mental health services, which is explicitly aimed at supporting the CHIME recovery processes and addresses two other practice domain levels. The REFOCUS intervention (9) involves training staff in three working practices which support personally defined recovery: understanding the service user’s values and treatment preferences as a starting point for care planning; assessing and amplifying strengths; and supporting goal-striving by the service user. Staff are also trained to use coaching as an interpersonal style in their working relationships with service users. The intervention is currently being evaluated across thirty community-based teams (10).

A remaining scientific challenge in England is to develop interventions that promote citizenship. These may require radical re-thinking of the role of clinicians, and are likely to involve community development initiatives based on partnership between people using and working in services, rather than individual-level treatments provided by professional experts.

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